Litholapaxy, with the Report of a Fatal Case.

At a late meeting of the New York Pathological Society (*Med.Record*, Dec. 20, 1879) Dr. E. L. KEYES presented specimens of five urinary calculi removed from five old men averaging over sixty-six years of age. The largest stone weighed 540 grains, and was removed by Thompson's washing-bottle in fifty-seven minutes, all told. The smallest stone weighed ninety-eight grains dry. It was removed in nineteen minutes. Dr. Keyes used his own modification of the lithotrite for crushing the stone in every case. Thompson's newest improvement in the washing-bottle was used in the last case. These stones made a series of twenty consecutive operations of rapid lithotrity performed by Dr. Keyes in connection with Dr. Van Buren. There had occurred one death. It was the fourth of the last five of the series. The bladder and kidneys were shown. This patient was a gentleman of sixty-seven. He was known to have pyelitis and kidney disease before the operation. His urine was very light, and contained casts and albumen besides the pus. The patient had been confined to bed by his maladies nine months. The stone had not been discovered. Dr. Keyes concluded to attempt rapid lithotrity as being the only operation offering the patient any chance. The bladder was pouched toward the right ureter. Thirteen minutes were consumed in catching the stone for the first time, and a seizure was only finally effected by turning the patient well upon the side. After one hour of manipulation, rendered very unsatisfactory by the pouched condition of the bladder, the sitting was terminated; one hundred and ninety grains were removed. No chill or serious consequence followed, and it was decided after three weeks, to undertake another sitting.

The second sitting lasted one hour. Debris, weighing when dry twenty-eight grains, required one hour for their removal, it being next to impossible to get the last fragments out of the pouch. An increase in the quantity of pus in the urine followed with almost total suppression, and death on the fifth day.

The right kidney was of about one-half its normal size, and the seat of interstitial nephritis. The left kidney was of full size, but similarly diseased, although to a less extent. Each kidney pelvis contained about a gill of thick pus, the left one some fragments of phosphatic stone. Both ureters were thickened and dilated. The urethra was healthy. The prostate was the seat of some central enlargement. The bladder was smooth and uncongested. It showed no evidence of violence. The mucous membrane was unbroken. The pouch at the site of the entrance of the right ureter into the bladder was very evident. The walls of the bladder were much thickened. Dr. Keyes maintained in this case that the patient's diseased condition was the cause of death, a catastrophe precipitated undoubtedly by the operation. He still believed, however, that the latter was justifiable under the peculiar circumstances of the case. In one very similar case, the same operation had been entirely successful at his hands. In the present instance, as shown by post-mortem examination, the operative manœuvres had not resulted in any direct physical lesions.

On the Treatment of Fractures.

The peculiarities of the treatment of subcutaneous fractures of the bones of the extremities at Greifswald Hospital consist in nearly always fixing the broken limb in a plaster bandage. The usual pasteboards are applied to the smaller bones, but to the large bones of the extremities only temporarily, if plaster cannot be had at once. Dr. MAX SCHÜLLER maintains that no bandage can be fixed so well as the plaster bandage: but its frequent inspection, and even renewal, are necessary, especially when considerable dislocation and effusion of blood have taken place. In this hospital, plaster bandages are also applied to compound fractures, but in connection with salicylic jute bandages. Dr. Max Schüller prefers the frequent renewal of the bandages, as the wound can then be disinfected and the whole limb thoroughly washed; because he regards the antiseptic cleansing of the fracture as particularly important. Dr. Max Schüller also recommends adequate drainage, even if fresh openings for the drainage-tubes have to be made, in order that the secretions may flow freely from the wound to the surface. In extensive fractures, in which disinfection can only be effected by removing all splinters, Dr. Max Schüller places a drainage-tube through the fractured locality itself. The drainage-tubes, however, may be removed, or at least shortened, after a few days. The bandages are changed under the application of spray, first every third or fourth day, but, after the first week, they can be left five, and, later, eight days. When the wound is healed, a plaster bandage is used for a long time to complete the consolidation. The chances of preserving a useful limb have been considerably increased by the antiseptic treatment, but even in unsuccessful cases this treatment makes the later necessary amputations less dangerous. In cases of compound fractures in which amputations are necessary, the adjacent joints have nearly always to be fractured simultaneously, or some parts of the extremities, whole masses of muscles, etc., have to be torn off. —*London Med. Record*, Nov. 15, 1879.

Treatment of Fracture of the Patella by Opening the Joint and Wiring the Fragments.

At a late meeting of the Medical Society of London, Mr. ROSE read notes of two cases of transverse fracture of the patella by muscular action, with separation of fragments, treated by him at the Royal Free Hospital by cutting into the joint antiseptically and wiring the fragments together.

Case 1 was that of a female aged thirty-two, stout and full habit of body, admitted Aug. 9th. The fracture was caused by her making an effort to save herself when falling from a cart. Rapid and excessive effusion into the joint followed, and, her leg being very fat, it was difficult to estimate the exact separation of the fragments, but it was about two inches. Mr. Rose operated on August 27th. The strictest antiseptic precautions were taken. The joint was opened by a longitudinal incision five inches long, over the middle and anterior aspect of the knee. Much dark coagula were squeezed out of the joint. The patellar fragments were then set free a little from their lateral ligamentous attachments, but only sufficiently so to get command over them for drilling. The fractured surfaces were thickly coated with organizing material, but there was no continuity between that on one surface and that on the other. A thin slice was taken from each fragment to expose the bony structure, and two holes were drilled in each obliquely one inch apart. Care was taken, first, to bring out the point of the awl close to, but not through the articular cartilage, so that the wire sutures should be entirely extra-articular when passed; secondly, to make the two holes in the upper fragment correspond with those in the lower. Thick silver wire sutures were then passed, which were gradually tightened, the rectus being well relaxed by flexing the thigh on the pelvis. In this way the fragments were brought into accurate apposition. A counter opening was then made on each side of the joint at the most dependent part, and skeins of horsehair drawn through to act as drainage. Bleeding was easily stopped, the wound was closed by carbolized silk sutures, the ends of the silver wires were cut about half an inch above the skin level, and antiseptic dressings applied, and a back splint. When the patient was placed in